Complete Summary

GUIDELINE TITLE

Medication-assisted treatment for opioid addiction in opioid treatment programs: Treatment of multiple substance use.

BIBLIOGRAPHIC SOURCE(S)

Treatment of multiple substance use. In: Batki SL, Kauffman JF, Marion I, Parrino MW, Woody GE, Center for Substance Abuse Treatment (CSAT). Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. p. 179-88. (Treatment improvement protocol (TIP); no. 43).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Multiple substance use (substance abuse) in patients with opioid addiction

GUIDELINE CATEGORY

Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Nurses
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To provide guidance on the treatment of patients in medication-assisted treatment for opioid addiction (MAT) who also abuse other substances, e.g., alcohol, amphetamines, benzodiazepines and other prescription sedatives, cocaine, and marijuana (THC [delta-9-tetrahydrocannabinol])

TARGET POPULATION

Patients in medication-assisted treatment for opioid addiction (MAT) who also abuse other substances, e.g., alcohol, amphetamines, benzodiazepines and other prescription sedatives, cocaine, and marijuana (THC [delta-9-tetrahydrocannabinol])

INTERVENTIONS AND PRACTICES CONSIDERED

Management of Multiple Substance Abuse

1. Detoxification, including inpatient detoxification if needed
2. Disulfiram therapy
3. Counseling
4. Participation in self-help groups
5. Intensive treatment interventions
6. Withholding of treatment (for patients who appear intoxicated)
7. Treatment of anxiety disorders with standard psychotropic medication and psychotherapy
8. Tobacco cessation therapy
9. Increased drug testing
10. Medication dosage adjustments
11. Discharge from medication-assisted treatment (MAT)
12. Referral

MAJOR OUTCOMES CONSIDERED

- Incidence of substance co-dependence
- Successful treatment outcome
- Adverse effects of multiple substance use
- Patient retention in treatment

- Abstinence from substance abuse

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature search involved careful consideration of all relevant clinical and health services research findings, practice experience, and implementation requirements.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic, Center for Substance Abuse Treatment (CSAT) invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the Treatment Improvement Protocols (TIP). These recommendations are communicated to a consensus panel

composed of experts on the topic who have been nominated by their peers. This consensus panel participates in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the contents of the TIP mirror the results of the group's collaboration.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the Treatment Improvement Protocol (TIP) is prepared for publication, in print and on line.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Except for naltrexone, which is used to treat alcohol dependence, the treatment medications used in medication-assisted treatment for opioid addiction (MAT) do not address nonopioid substance use directly, although patients stabilized on adequate treatment medication are less likely to abuse other substances than patients who are undermedicated. Because multiple substance use during MAT may complicate treatment greatly, the consensus panel recommends that staff members be trained to recognize the pharmacologic and psychosocial effects of both opioid and nonopioid substances of abuse. Opioid treatment programs (OTPs) should have treatment options available to address multiple substance use either directly or by referral.

An essential purpose of preliminary assessment is to determine whether new patients are abusing or are dependent on substances other than opioids. If one of these problems is identified, OTPs should adjust treatment plans and the types of services provided accordingly. OTPs should not exclude patients automatically from MAT who test positive for illicit drugs other than opioids. Treatment providers should treat patients for their concurrent substance abuse aggressively

or refer them appropriately. Providers should try to understand and address the underlying causes of concurrent substance use.

Prevalence of Multiple Substance Use in MAT

Patients Entering OTPs Who Abuse Other Substances

Exhibit 11-1 in the original guideline document presents Treatment Episode Data Set (TEDS) data on heroin and other substances used by people admitted to OTPs in 2000. Exhibit 11-2 in the original guideline document summarizes results of a large-scale study of co-dependence in 716 patients admitted to OTPs in Baltimore, Maryland, over a 5-year period (1989 to 1994).

Common Drug Combinations Used by Patients in MAT

Exhibit 11-3 in the original guideline document summarizes reasons patients in MAT give for using particular combinations of substances, based on the consensus panel's experience.

Effects of Other Substance Use

Alcohol

Treatment for alcohol dependence involves a comprehensive approach combining detoxification if needed, counseling, medications such as disulfiram, and participation in mutual-help groups. Many groups do not support use of maintenance medication. Other interventions have met with limited success.

Benzodiazepines

In the experience of the consensus panel, patient use of benzodiazepines negatively affects attendance at treatment sessions and progress in MAT. Regular benzodiazepine use for 3 months or more may be associated with physiologic dependence, even when benzodiazepines are taken in prescribed doses. Patients who are abusing or dependent on benzodiazepines usually need detoxification and more intensive treatment interventions to remain safely in MAT.

Nonbenzodiazepine Sedatives

Nonbenzodiazepine sedatives such as intermediate- or short-acting barbiturates or glutethimide are more likely than benzodiazepines to produce lethal overdose because people who abuse them develop tolerance for their sedative and euphoric effects but not for their respiratory-depressant effects. Therefore, as these people increase their dosages to get high, they suddenly can overdose to respiratory depression. People who are opioid addicted and abuse nonbenzodiazepine sedatives usually need inpatient detoxification before starting MAT or may do better with referral to a long-term, residential program such as a therapeutic community. Nonbenzodiazepine sedatives induce cytochrome P450 3A, an enzyme involved in methadone, levo-alpha acetyl methadol (LAAM), and buprenorphine metabolism, and can make stabilization difficult.

The consensus panel recommends that OTPs withhold treatment medication for patients who appear intoxicated with a sedative-type drug until intoxication has cleared and patients are either detoxified from sedatives or confirmed not to be sedative dependent. Nonbenzodiazepine sedative and barbiturate abuse is rare in most areas. These medications are less widely abused than in the past, because benzodiazepines are less dangerous and easier to obtain in many areas.

Cocaine and Other Stimulants

Stimulant abuse, especially cocaine, is another serious problem in many OTPs. Adverse effects of these substances include cardiovascular effects (hypertension, stroke, arrhythmias, myocardial infarction), respiratory effects (perforation of nasal septum, bronchial irritation) if inhaled or smoked, or mental effects (anxiety, depression, anger, paranoia, psychotic symptoms). Patients in MAT who abuse stimulants may be disruptive if the stimulants have severe mental effects, and these patients may have problems with mood swings and compliance with group or individual therapy.

Another concern for patients in MAT who use cocaine is concurrent alcohol use. The combination of alcohol and cocaine is popular because it can create a more intense high and less intense feelings of inebriation than either substance alone. Individuals also use alcohol to temper discomfort when they come down from a cocaine-induced high. Patients in MAT who abuse both alcohol and cocaine are significantly more difficult to engage and retain in treatment than patients who do not abuse all three substances. In addition, cocaethylene, a psychoactive derivative of cocaine formed exclusively during the combined administration of cocaine and alcohol, can increase the cardiotoxic effects of either substance alone. The combination of alcohol and cocaine tends to have exponential effects on heart rate and may increase violent thoughts and tendencies. The mixture of opioids, cocaine, and alcohol can be lethal and has been identified as a leading cause of accidental overdose.

More research on the benefits of disulfiram therapy for cocaine dependence during MAT is needed.

Marijuana

OTPs vary in whether they require delta-9-tetrahydrocannabinol (THC)-free drug tests before patients can qualify for or continue take-home medication privileges. The consensus panel recommends that OTPs address patient THC use because, as with other substances of abuse, THC increases the probability that patients will engage in activities that put them at higher risk of relapse to opioid use, other health problems, other related illicit activities, and legal problems.

Patients in MAT sometimes use THC to self-medicate for anxiety or insomnia. Approaches to address THC use in these patients include increased counseling, treatment of their anxiety disorders with standard psychotropic medications and psychotherapy, and requirements that drug tests be free of THC before patients can qualify for take-home medication. Unlike people addicted to nonopioid substances, patients in MAT who are opioid addicted rarely seek treatment for THC dependence. Therefore, it has received less attention in OTPs than in other substance abuse treatment programs.

Nicotine

Tobacco-smoking-related illnesses are a major cause of morbidity and mortality among patients in MAT as they are in the general population.

Many OTPs avoid addressing nicotine dependence because it may create additional stress for patients.

The consensus panel believes that OTPs should address nicotine dependence routinely. In addition, because effective medications are available, tobacco cessation should be a regular part of patients' treatment plans.

Management of Multiple Substance Use in MAT

Although some studies have indicated that patients in MAT reduce other substance use significantly when they receive adequate doses of methadone, LAAM, or buprenorphine, none of these medications reliably and consistently stopped nonopioid abuse in studies reported. A major concern is how to determine what level of other substance abuse by patients indicates that MAT is insufficient and other treatments should be tried or that MAT should be stopped, perhaps against patient wishes.

Some have argued for early treatment discharge if patients continue using multiple substances. In addition, some State regulations set specific timetables for compliance, although the requirement is unsupported by research. Some OTP staff members may feel that patients' continued use of alcohol and illicit drugs, despite progress in recovery from opioid addiction, reflects negatively on OTP credibility and that these patients are taking the places of people who would benefit more from MAT. Patients who continue using illicit drugs sometimes erode the morale of other patients, who may conclude that treatment compliance and abstinence are optional.

Policies favoring treatment termination for patients who use substances negate a fundamental principle--that longer retention in treatment is correlated highly with increased treatment success. In fact, substantial remission from all substance use is a common and positive outcome of MAT, particularly when treatment includes regular drug counseling and other psychosocial services. Consensus panel members have found that, if patients with secondary substance use problems remain in MAT and staff members address overall substance abuse patterns for these patients, many patients stop using nonopioid and nonprescribed substances.

Changing staff attitudes can be helpful to both patients and staff. Abuse of other substances along with opioid addiction presents many problems and challenges for treatment providers and patients. Without treatment, a person with these problems may continue criminal activity; remain obsessed with substance use; experience severe financial, vocational, and personal problems; and be at increased risk for overdose death.

Given the importance of retention in MAT for positive outcomes, the consensus panel agrees that a policy of discharge for other substance use is seldom appropriate. Instead of setting standard timetables for discharge, limits should be

determined on a case-by-case basis. Patient discharge should be done with great caution and only when staff members have exhausted all reasonable alternatives. When grappling with these difficult problems, providers should keep in mind where patients started, how far they have progressed, the degree to which they are engaged in treatment, whether all available interventions have been tried, the risk–benefit ratio of keeping these patients in treatment versus discharging them, and a realistic expectation for patients, given the resources available. If discharge must occur, staff members should work with patients to arrange transfer to another program where a treatment slot is open and they can obtain more benefit.

Other Procedures

A key element in treating multiple substance use in an OTP is the need for intensified services and heightened structure and supervision. Because few chronic diseases respond to a single care model, OTPs need a variety of techniques for patients who abuse multiple substances. These techniques should incorporate available medical, mental health, and social services. Usually patients who abuse multiple substances require a more intensive level of care for a limited period. Treatment providers also should have referral agreements with inpatient facilities for brief detoxification from nonopioid substances, extended stabilization before reentry into an OTP, or admission to a therapeutic community, residential treatment, or other long-term, more structured and controlled environment. OTPs can enter into agreements with residential treatment programs to allow continued MAT along with treatment for other substance dependence.

A common problem is that some OTP staff members and patients assume that stopping opioid and injection drug use is the sole objective of treatment. Use of cocaine and other substances should cause concern because it undermines patient stability. Nonetheless, use of some substances such as THC may be viewed as less serious unless clear evidence exists of impaired functioning. Many people entering an OTP regard alcohol use as acceptable because it is legal. Changing such attitudes and behaviors requires patience and effort. OTPs should have clear policies declaring the desirability of cessation of all substance use. These policies should clarify any ambiguity about abstinence from nonprescribed medications but encourage therapeutic use of medications that are effective to treat legitimate, diagnosed conditions. OTPs should encourage abstinence from alcohol and nicotine, but it is difficult to require it because these are legal substances. However, OTPs may withhold medication if patients have consumed alcohol shortly before or are intoxicated during treatment and should address alcohol problems.

The consensus panel believes it is helpful, both when patients are admitted to an OTP and throughout treatment, to maintain the position that opioid use is only the most obvious part of patients' problems and that the role of all intoxicants (both licit and illicit) in patients' lives and their overall substance-using lifestyle are other important issues. Patients in MAT should recognize that use of any intoxicant undermines their progress.

Dosage Adjustments

During the dosing period, OTPs should ensure that patients' dosages suppress withdrawal and produce significant cross-tolerance for opioids of abuse. Patients may be abusing other drugs to self-medicate withdrawal symptoms caused by inadequate dosages or other factors that affect medication metabolism. In this case, raising the dosage or splitting doses may lessen other substance use.

Increased Counseling and Other Psychosocial Services

Numerous studies have shown that regular counseling is associated with a reduction in opioid and other substance use by patients in MAT.

Increased Drug Testing

One obstacle to detecting other substance use during MAT is that infrequent drug tests primarily identify only those patients who use substances frequently, for example, daily. Early detection and intervention requires occasional periods of more intensive, random drug testing. OTPs, however, should have objective policies that require combining increased drug testing with more intensive counseling. Testing frequency might be used as a contingency, with more negative tests for illicit drugs resulting in less frequent testing.

Inpatient Detoxification and Short-Term Stabilization

Use of alcohol or other central nervous system (CNS) depressants with opioids may cause depression of respiration, loss of consciousness, life-threatening withdrawal reactions, and increased risk of lethal overdose. This type of withdrawal is not treatable with methadone. Signs and symptoms of withdrawal from CNS depressants include elevated body temperature, hypertension, rapid pulse, confusion, hallucinations, and intractable seizures. When a patient in MAT abuses a CNS depressant, the depressant should be withdrawn medically from the patient's system, and the opioid treatment medication should be continued with consideration of the need for a dosage increase.

The patient may require inpatient detoxification from CNS depressants and should continue MAT during the inpatient stay. In addition, a history of seizures or toxic psychosis during withdrawal from a sedative-hypnotic or anxiolytic drug or from alcohol is an absolute indication for inpatient detoxification.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate treatment of multiple substance abuse in patients in medication-assisted treatment for opioid addiction (MAT)

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), or Department of Health and Human Services (DHHS). No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Chapter 14, Administrative Considerations, in the original guideline document, covers the challenging administrative aspects of managing and staffing the complex and dynamic environment of an opioid treatment program (OTP). Successful treatment outcomes depend on the competence, values, and attitudes of staff members. To develop and retain a stable team of treatment personnel, program administrators must recruit and hire qualified, capable, culturally sensitive individuals; offer competitive salaries and benefit packages; and provide good supervision and ongoing training. Implementing community relations and community education efforts is important for opioid treatment programs. Outreach and educational efforts can dispel misconceptions about medication-assisted treatment for opioid addiction and people in recovery. Finally, the chapter provides a framework for gathering and analyzing program performance data. Program evaluation contributes to improved treatment services by enabling administrators to base changes in services on evidence of what works. Evaluation also serves as a way to educate and influence policymakers and public and private payers.

Refer to Chapter 14 in the original guideline document for full details (see "Companion Documents" field in this summary).

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Treatment of multiple substance use. In: Batki SL, Kauffman JF, Marion I, Parrino MW, Woody GE, Center for Substance Abuse Treatment (CSAT). Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. p. 179-88. (Treatment improvement protocol (TIP); no. 43).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 43 Consensus Panel

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site. Also available in Portable Document Format (PDF) from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Executive summary. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. xvii-xx. (Treatment improvement protocol (TIP); no. 43).
- Introduction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 1-10. (Treatment improvement protocol (TIP); no. 43).
- History of medication-assisted treatment for opioid addiction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 11-23. (Treatment improvement protocol (TIP); no. 43).
- Pharmacology of medications used to treat opioid addiction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 25-42. (Treatment improvement protocol (TIP); no. 43).
- Administrative considerations. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 225-240. (Treatment improvement protocol (TIP); no. 43).
- Appendix D: Ethical considerations in MAT. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 297-304. (Treatment improvement protocol (TIP); no. 43).

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site. Also available in Portable Document Format (PDF) from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Web site.

The following are also available:

- Knowledge Application Program. KAP keys for clinicians. Based on TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. 20 p. Electronic copies: Available in Portable Document Format (PDF) from the SAMHSA Web site.
- Quick guide for clinicians. Based on TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. 39 p.

Electronic copies: Available in Portable Document Format (PDF) from the SAMHSA Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on December 27, 2005. The information was verified by the guideline developer on January 23, 2006.

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